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IN THE

Supreme Court of the United States

NORTH BROWARD HOSPITAL DISTRICT, *et al.*,

Petitioners,

v.

DONNA E. SHALALA, Secretary
Department of Health and Human Services,

Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the District of Columbia Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

Whether the Secretary of Health and Human Services properly construed the phrase "total *of such* net inpatient care revenues," in a provision of the Medicare statute governing Medicare payment to hospitals that serve indigent patients, to mean "total net inpatient care revenues," thus rendering the term "of such" mere surplusage and other statutory language totally superfluous. 42 U.S.C. § 1395ww(d)(5)(F)(i)(II) (emphasis added).

PARTIES TO THE PROCEEDINGS

The petitioners are North Broward Hospital District d/b/a Broward General Medical Center, North Broward Hospital District d/b/a North Broward Medical Center, and North Broward Hospital District d/b/a Imperial Point Medical Center, plaintiffs in the district court and appellees in the court of appeals.

The respondent is Donna E. Shalala, Secretary, Department of Health and Human Services, defendant in the district court and appellant in the court of appeals.

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OPINIONS BELOW

The opinion of the court of appeals (App. at 1a -22a) is reported at 172 F.3d 90. The opinion of the district court (App. at 23a-38a) is reported at 997 F. Supp. 41.

JURISDICTION

The judgment of the court below was entered on April 27, 1999. Rehearing was denied on July 6, 1999. App. at 40a. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISION INVOLVED

The key statutory provision at issue is 42 U.S.C. § 1395ww(d)(5)(F)(i)(II). It is reproduced in the Appendix at 43a.

STATEMENT

At issue is whether the Secretary of Health and Human Services (the "Secretary") may treat as surplusage the words "of such" that appear in a portion of the Medicare statute commonly known as the Pickle Amendment, 42 U.S.C. § 1395ww(d)(5)(F)(i)(II). The Secretary's failure to give meaning to these words of Congress significantly affects large urban hospitals, such as petitioners, that serve a large number of indigent patients.

The Pickle Amendment is one of two provisions that establish an additional Medicare payment for hospitals providing care for a disproportionate share of low-income patients. Specifically, a hospital qualifies for the Pickle Amendment if it:

> can demonstrate that its *net inpatient care revenues (excluding any of such revenues attributable to this subchapter [Medicare] or State plans approved under subchapter XIX of this chapter [Medicaid])* . . . for indigent care from State and local government sources exceed 30 percent of its *total of such net inpatient care revenues* . . . .

42 U.S.C. § 1395ww(d)(5)(F)(i)(II) (emphasis added).

The statute establishes a common pool of "revenues" from which both the numerator and the denominator are drawn, *i.e.*, "net inpatient care revenues (excluding any of such revenues attributable to [Medicare] or [Medicaid])." The numerator consists of the net inpatient care revenues from

this pool that are "for indigent care from State and local government sources." The denominator consists of the "total of such net inpatient care," *i.e.*, the total pool, and is the subject of the instant controversy.

The Secretary contends that the denominator's phrase "total *of such* net inpatient care revenues" should be construed as if it actually read "total net inpatient care revenues," without qualification. In other words, the Secretary -- contrary to this Court's decision in *United States v. Bowen,* 100 U.S. 508 (1879), and established tenets of statutory construction — treats the words "of such" as mere surplusage.

Petitioners, in contrast, submit that the words "of such" plainly incorporate an antecedent phrase that qualifies the term "net inpatient care revenues." The only antecedent use of the term "net inpatient care revenues" is one which is immediately modified by the parenthetical "(excluding any of such revenues attributable to [Medicare] or [Medicaid])." 42 U.S.C. § 1395ww(d)(5)(F)(i)(II). Thus, the plain language of the statute clearly excludes Medicare and Medicaid revenues from the denominator.

The district court (per Judge Stanley Harris) agreed that "a plain language analysis" mandates petitioners' construction under the first prong of review established by this Court in *Chevron U.S.A., Inc. v. National Resources Defense Council, Inc.*, 467 U.S. 837, 843 (1984), because it "succeeds in giving effect to every word describing the denominator." 997 F. Supp. 41, 45 (D.D.C. 1998); App. at 30a. The court of appeals reversed.

Further review is warranted because (1) the court of appeals' decision conflicts with this Court's decision in *United States v. Bowen,* 100 U.S. 508 (1879); (2) the court of appeals' decision conflicts with the fundamental canon of

statutory construction that every word in a statute must be given effect if possible; (3) the court of appeals' decision conflicts with this Court's "deep reluctance" to adopt a construction that makes another statutory provision superfluous, *Pennsylvania Dep't of Public Welfare v. Davenport*, 495 U.S. 552, 562 (1990) (citation omitted); and (4) the issue involves a major provision in the Medicare statute that significantly affects large urban hospitals that serve indigent patients.

A. Medicare Reasonable Cost Reimbursement.

In 1965, Congress enacted the Medicare program primarily to furnish health insurance for the elderly. Social Security Amendments of 1965, Pub. L. No. 89-97, § 102(a). From that time until 1983, the Medicare program reimbursed participating hospitals the "reasonable cost" incurred in furnishing services to Medicare patients. *See Good Samaritan Hosp. v. Shalala,* 508 U.S. 402, 404 (1993) (citing 42 U.S.C. § 1395f(b)(1)).[1]

Effective with cost reporting years beginning on or after October 1, 1983, Congress adopted a prospective payment system ("PPS") to reimburse most hospitals for inpatient operating costs. Social Security Amendments of 1983, Pub. L. No. 98-21, § 601(e), 97 Stat. 152-53 (enacting 42 U.S.C. § 1395ww(d)). Under PPS, hospitals are paid a fixed amount for each of approximately 500 diagnosis-related groups, subject to certain payment adjustments. 42 U.S.C. § 1395ww(d).

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[1] The only exception was if a hospital's costs exceeded its prevailing charges, in which case it was reimbursed its charges. 42 U.S.C. § 1395f(b)(1).

B. The Medicare Claims and Appeals Process.

The Secretary has contracted Medicare audit and payment functions to organizations (usually insurance companies) known as fiscal intermediaries. 42 U.S.C. § 1395h; *Bethesda Hosp. Ass'n v. Bowen,* 485 U.S. 399, 400-01 (1988). At the close of a year, a Medicare provider files a cost report with its Medicare intermediary, which audits the cost report and issues a determination of the costs recognized as reasonable in a notice of program reimbursement ("NPR"). 42 C.F.R. § 405.1803(a)(1); *see also* 42 U.S.C. § 1395oo(a)(1)(A)(i); *Bethesda Hosp. Ass'n,* 485 U.S. at 401. A provider dissatisfied with the intermediary's determination may appeal to the Provider Reimbursement Review Board ("PRRB" or "Board") and eventually file a court suit. 42 U.S.C. § 1395oo(f)(1).

C. The Medicare Disproportionate Share Adjustment.

When Congress established Medicare PPS in 1983, it authorized the Secretary to provide an adjustment to PPS payments for hospitals that serve a disproportionate share of low-income patients. *See* Social Security Amendments of 1983, Pub. L. No. 98-21, § 601(e), 97 Stat. 152-53 (codified at 42 U.S.C. § 1395ww(d)(5)(C)(i)). When the Secretary declined to make such an adjustment, 48 Fed. Reg. 39,783 (1983), Congress responded by directing the Secretary to develop and publish a disproportionate share definition and identify the hospitals that meet the definition by December 31, 1984. Deficit Reduction Act of 1984, Pub. L. No. 98-369, § 2315(h), 98 Stat. 494, 1080.

By July 1985, the Secretary had not yet complied with this congressional mandate; a district court thus ordered the Secretary to implement the disproportionate share statutory

provision. *Samaritan Health Ctr. v. Heckler*, 636 F. Supp. 503, 518 (D.D.C. 1985). In 1986, after the Secretary issued extremely narrow disproportionate share criteria, *see* 50 Fed. Reg. 53,398-400 (1985), Congress amended the Medicare statute to prescribe statutory definitions of disproportionate share hospitals, Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), Pub. L. No. 99-272, § 9105, 100 Stat. 158; *Samaritan Health Ctr. v. Bowen*, 646 F. Supp. 343, 345-47 (D.D.C. 1986).

The Medicare statute establishes two alternative methods for establishing qualification as a disproportionate share hospital ("DSH"). The first, and by far the more common, is generally known as the standard or the proxy method. 42 U.S.C. § 1395ww(d)(5)(F)(i)(I), (v). Hospitals qualify under this standard if a specified percentage of their total inpatient care days (their so-called "disproportionate patient percentage") is attributable to Medicare patients eligible for Supplemental Security Income[2] or patients eligible for Medicaid.[3] 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I). The second method is set forth in 42 U.S.C. § 1395ww(d)(5)(F)(i)(II), and is commonly referred to as the Pickle Amendment (after its sponsor, former Representative J.J. Pickle). Under the

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[2] Supplemental Security Income (title XVI of the Social Security Act) furnishes financial assistance to indigent persons who are aged, blind, or disabled. 42 U.S.C. § 1381 *et seq.*

[3] Medicaid (Title XIX of the Social Security Act) is a cooperative federal-state program that furnishes health care to indigent persons who meet specified eligibility requirements. 42 U.S.C. § 1396 *et seq.*; *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 502 (1990). States participating in the Medicaid program have substantial discretion in selecting the benefits provided. *See generally* 42 U.S.C. § 1396d(a). However, all states must furnish certain minimum benefits, including "inpatient hospital services." *See id.* § 1396d(a)(1).

Pickle Amendment, as described above, a hospital may qualify for a DSH adjustment based on net inpatient care revenues received from state and local government sources for indigent care. *Id.*[4]

D. Intermediary Decision and PRRB Proceedings.

Petitioners are three public, not-for-profit, general acute care hospitals located in Broward County, Florida. They are owned and operated by the North Broward Hospital District, a special taxing district created by Florida law. All three petitioners furnish inpatient hospital services under the Medicare program and provide substantial services to low-income patients.

Petitioners claimed entitlement to the Pickle Amendment adjustment. Based on advice received from officials at the Health Care Financing Administration ("HCFA"), the

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[4] The disproportionate share adjustment percentage under the Pickle Amendment, 42 U.S.C. § 1395ww(d)(5)(F)(iii), has increased significantly over the years. The original adjustment, which became effective for discharges occurring after April 30, 1986, was 15%. *See* COBRA, Pub. L. No. 99-272, § 9105(a), 100 Stat. 159. The adjustment was increased to 25% for discharges occurring after September 30, 1988 (Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, § 4003(b)(1), 101 Stat. 1330-46); to 30% for discharges occurring after March 31, 1990 (Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6003(c)(3), 103 Stat. 2142); and to 35% for discharges occurring after September 30, 1991 (Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 4002(b)(2), 101 Stat. 1388-32). The current adjustment is still 35%, but it is subject to certain reductions mandated by the Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4403(a), 111 Stat. 398-99. 42 U.S.C. § 1395ww(d)(5)(F)(iii), (ix). During the three cost reporting years under appeal in this case, the Pickle Amendment adjustment ranged from 15% (first three months) to 25% (next 18 months) to 30% (final 15 months).

Medicare fiscal intermediary denied petitioners' claims. Joint Appendix ("J.A.") at 113-18.[5] Petitioners filed two group appeals with the PRRB challenging the denial of the Pickle Amendment adjustment — one for fiscal years 1989 and 1990 and the other for fiscal year 1991. Administrative Record ("A.R.") at 447-49, 899-901.[6]

Prior to the Board hearing in these appeals, the parties filed stipulations in which they agreed on the methodology for determining qualification for the Pickle Amendment adjustment with one exception. J.A. at 80, 83. The intermediary contended that net inpatient care revenues attributable to Medicare and Medicaid must be included in the net inpatient care revenues used for the denominator. *Id.* Petitioners contended that net inpatient care revenues attributable to Medicare and Medicaid must be excluded from the denominator. *Id.*

After conducting a live hearing for both group appeals, A.R. at 114-97, the PRRB issued unanimous decisions reversing the intermediary's disallowances and upholding petitioners' entitlement to Pickle Amendment adjustments for the years under appeal, *id.* at 49-64, 97-112. Because the Pickle Amendment defines the denominator as a hospital's "total *of such* net inpatient care revenues," the PRRB ruled, the denominator could not consist of "total net inpatient care revenues," as the intermediary contended. *Id.* at 60-61, 108-09 (emphasis added). Instead, the PRRB concluded, the denominator must consist of only the net inpatient care revenues that were previously identified, *i.e.*, net inpatient

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[5] The "Joint Appendix" was filed with the Court of Appeals on September 25, 1998.

[6] The "Administrative Record" was filed with the District Court on March 14, 1996.

care revenues excluding those attributable to Medicare and Medicaid. *Id.* The PRRB also relied on a passage in the 1987 Conference Report accompanying an amendment to the statute, which states that a hospital may qualify if "it can demonstrate that more than 30 percent of *its inpatient care revenues (excluding any Medicare or Medicaid revenues)* are provided by State and local government payments for indigent care." *Id.* at 62, 110 (emphasis added by the Board). The PRRB noted that if the intermediary's construction were correct, the parenthetical phrase would be located at the end of the sentence, rather than after the words "its inpatient care revenues." *Id.*

On November 16, 1995, the HCFA Administrator reversed the PRRB's decisions. *Id.* at 69-79. Stating, erroneously, that the "statute uses the term 'such revenues' twice in the same sentence," the Administrator concluded that the statute "contains incontrovertible referential ambiguity." *Id.* at 77. He also found the legislative history and HCFA's regulations ambiguous. *Id.* at 78-79. Given what he characterized as "the ambiguous statutory and regulatory language and the legislative history," the Administrator elected to defer to the construction of his subordinates in HCFA. *Id.* at 79.

E. District Court Decision.

Pursuant to 42 U.S.C. § 1395oo(f)(1), petitioners filed suit in the United States District Court for the District of Columbia to challenge the HCFA Administrator's decision. The district court reversed the administrative decision, finding that the plain words of the statute mandate petitioners' construction. In the district court's view, the words "of such" preceding "net inpatient care revenues" clearly refer to the "last antecedent," *i.e.*, "net inpatient care revenues (excluding any of such revenues attributable to [Medicare] or

[Medicaid])." 997 F. Supp. 41, 45 (D.D.C. 1998); App. at 30a. Moreover, the district court concluded, the Secretary's construction treats the words "of such" as surplusage, thus failing to give effect to these words, as required by established canons of construction. 997 F. Supp. at 46; App. at 31a. Finally, the district court found no clearly expressed congressional intent in the legislative history that would justify a departure from the construction mandated by the plain words of the statute. 997 F. Supp. at 46-48; App. at 33a-36a.

F. Court of Appeals Decision.

The Court of Appeals for the District of Columbia Circuit reversed the district court's judgment. The court of appeals rejected the view that the word "such" necessarily serves "some limiting or particularizing role." 172 F.3d at 95; App. at 10a-11a. It concluded that the Secretary's interpretation, though stripping the word "such" of a particularizing role, did not render it mere surplusage because "it still serves a role in 'helping the reader to identify concepts that have already been employed in a long or complicated piece of writing.'" 172 F. 3d at 95; App. at 11a (quoting Secretary's Reply Brief at 18). The court of appeals further found the words "total of" "at least suggestive that the phrase following [*i.e.*, 'such net inpatient care revenues'] is to be all-encompassing, without exclusions." *Id.* at 96; App. at 13a. Similarly, the court noted that the purported prior occurrence of the term "such revenues" (in the parenthetical describing the Pickle numerator) "does seem to provide at least some support for construing the latter occurrence of 'such revenues' (and thus the amended 'such net inpatient care revenues') as referring to the same antecedent." 172 F.3d at 98; App. at 15a. The court of appeals dismissed the Conference Report to the 1987 amendment to the statute, which supports petitioners' reading

of the provision, as "mere 'legislative dicta.'" 172 F.3d at 98; App. at 17a (quoting *Dunn v. Commodity Futures Trading Comm'n,* 519 U.S. 465, 478 (1997)).

REASONS FOR GRANTING THE PETITION

A. Importance of Case.

The question presented by this case is important.

1. At issue is the proper construction of a major federal statute of importance in all States of the Union and the District of Columbia. The statute directly and substantially affects the proper Medicare reimbursement for urban hospitals that serve indigent patients. Further, the court of appeals' decision carries special weight because the District of Columbia Circuit is the only venue to which all Medicare providers have access. 42 U.S.C. § 1395oo(f)(1).

2. The court of appeals' decision directly conflicts with this Court's decision in *United States v. Bowen,* 100 U.S. 508 (1879), in which this Court held, first, that the word "such" must be given meaningful effect under a plain language reading of a statute; and, second, that "such" refers to the last particularized antecedent. In this case, however, the Secretary and the court of appeals failed to give the word "such" any meaningful effect. In particular, the court of appeals rejected the only possible construction of the term, one which — consistent with *Bowen* — would read it as referring to a particularized antecedent.

3. This case involves important issues regarding the proper principles for reviewing agency constructions of federal statutes. The court of appeals purported to apply *Chevron,* but found ambiguity where none exists. It did so only by ignoring two bedrock principles of statutory construction requiring, as a threshold matter, (1) that effect be

given to each word of a statute and (2) that construction of one provision not render another provision superfluous. The court of appeals abdicated its role under *Chevron,* applying deference even though traditional tools of statutory construction required resolution of the matter under *Chevron* step one. Further review is warranted to clarify the role of the judiciary in applying principles of statutory construction to determine in the first instance whether the plain language of a statute evidences the intent of Congress.

B. The Secretary's Reading Conflicts With *United States v. Bowen.*

At issue here is the construction of the words "of such" in the Pickle Amendment, which renders a hospital eligible for a "DSH" payment if it:

> can demonstrate that its *net inpatient care revenues (excluding any of such revenues attributable to [Medicare] or [Medicaid]),* during the cost reporting period in which the discharges occur, for indigent care from State and local government sources exceeds 30 percent of its *total of such net inpatient care revenues* during the period.

42 U.S.C. § 1395ww(d)(5)(F)(i)(II) (emphasis added). The parties disagree over whether the parenthetical exclusion of Medicare and Medicaid payments that modifies the first occurrence of the phrase "net inpatient care revenues" also modifies the second occurrence of that phrase, by virtue of the statute's reference to "total *of such* net inpatient care revenues." *Id.* (emphasis added).

In the Secretary's view, the parenthetical phrase modifies only the first occurrence of "net inpatient care revenues." In other words, the Secretary construes the words "total *of such* net inpatient care revenues" to mean "total net inpatient care

revenues," thus effectively eliminating the words "of such" from the statute. Petitioners, in contrast, contend that the words "of such" must have meaning. By using the phrase "total *of such* net inpatient care revenues," Congress could only have been referring to the antecedent phrase "net inpatient care revenues," as modified by the parenthetical that follows the only prior occurrence of those same four words.

The court of appeals' decision, which gives no effect to the word "such," flatly conflicts with a decision of this Court which addressed, under closely analogous facts, the meaning of the word "such." In *United States v. Bowen,* 100 U.S. 508 (1879), this Court held, first, that the word "such" must be given meaningful effect under a plain language reading of a statute; and, second, that ordinary parlance makes clear that "such" refers to a particularized antecedent. *Bowen* mandates the same conclusion in this case.

The statute at issue in *Bowen* provided, as an initial matter, that a soldier entitled to a disability pension was not precluded from admission to a Soldiers' Home because of his failure to contribute to the Home's funds. The law went on to state, however, that "*all such pensioners* shall surrender their pensions to the Soldiers' Home during the time they remain there and voluntarily receive its benefits." 100 U.S. at 511 (emphasis added; quotation marks omitted). The question before this Court was whether all pensioners had to surrender their pensions while they were residents of the Soldiers' Home (as the government contended), or whether that obligation applied only to "such pensioners" who had not contributed to the funds of the Home (as the plaintiff pensioner contended).

The Court rejected the government's construction, reasoning as follows:

> There is no other class of pensioners described in that section to whom the word *such* can refer than those who have not contributed to the funds of the home. . . . There is no antecedent use of the word "pensioners" in the chapter of which sect. 4820 is a part, and which embraces the legislation of Congress concerning the Soldiers' Home, to which the word *such* can refer, but the immediately preceding sentence in the same section.

Id. at 512 (emphasis in original). So too, in the instant case, "there is no antecedent use of the word[s 'net inpatient care revenues'] in the chapter of which [the Pickle Amendment] is a part . . . to which the word *such* can refer, but the immediately preceding [reference] in the same section." *Id.*

In *Bowen*, this Court continued:

> If the construction claimed by counsel for the government be correct, that word is useless, for it would express the idea with precision by reading, "But all pensioners shall surrender their pensions to the Soldiers' Home during the time they remain therein and voluntarily receive its benefits." The question, therefore, is whether we shall read the section "all pensioners" or "all *such* pensioners."

Id. Here again, in the instant case, "[i]f the construction claimed by counsel for the government be correct, th[e] word ['such'] is useless, for it would express the idea with precision by reading '[total net inpatient care revenues].'" *Id.* "The question, therefore, is whether [to] read the section '[total net inpatient care revenues]' or '[total *of such* net inpatient care revenues].'" *Id.*

On this ultimate question, this Court in *United States v. Bowen* held that the word "such" must be given its common

meaning: "[t]he word . . . has an appropriate reference to the class of pensioners who have not contributed to the funds of the institution, and no sound canon of construction will authorize us to disregard it, when to do so changes very materially the meaning of this section." *Id.* at 513. By the same logic, the word "such" in "total of such net inpatient care revenues" must refer to the antecedent identifying the intended net inpatient care revenues, and "no sound canon of construction" authorizes courts to disregard this antecedent. In light of *Bowen,* there is simply no room for the Secretary to argue seriously that the phrase "total of such net inpatient care revenues" may be construed as though the words "of such" were not there. *Bowen* precludes the construction adopted by the court of appeals.

C. The Secretary's Reading Ignores The Plain Meaning Of The Medicare Statute.

The Secretary's failure to give the words "of such" any meaning violates a fundamental tenet of statutory construction applied by this Court in *Bowen*. It also renders superfluous the Pickle Amendment's express exclusion of Medicare funding. Because the court of appeals also ignored the plain meaning of the Medicare statute, thus sidestepping its appropriate role under *Chevron*, further review is appropriate.

The permissibility of the Secretary's interpretation of the Pickle Amendment, 42 U.S.C. § 1395ww(d)(5)(F)(i)(II), turns on the familiar two-step analysis set forth in *Chevron*

U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984).[7] Under *Chevron*, courts charged with reviewing an agency interpretation of a statute must ask, first, "whether Congress has directly spoken to the precise question at issue." *Id.* at 842. If by "employing traditional tools of statutory construction," *id.* at 843 n.9, a court determines that "the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress," *id.* at 842-43.

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[7] Although *Bowen* predated *Chevron*, this Court, in fact, performed what is now known as a *Chevron* step one analysis in that case. The government's claim for an alternative reading in *Bowen* was — as in this case — based on the statute's legislative history instead of its plain language. Although this Court in *Bowen* noted that the language of an old law is "a valuable source of information" in a case of ambiguity, it concluded that the meaning of the statute, consistent with "accepted canons of interpretation," was "plain" and left "room for no other construction" than that which was adopted by the Court. 100 U.S. at 513. Here too resort to the legislative history is unnecessary and improper, as a plain language reading using standard tools of statutory construction readily resolves the matter.

In any event, to the extent the government argues here that the legislative history supports a reading that renders the word "such" a nullity, that argument is refuted by the legislative history of the 1987 amendment to the law which added the words "net inpatient care" after "such." Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, § 4009(j)(3)(A), 101 Stat. 1330-59. The Conference Report describes the effect of the Pickle Amendment as follows:

> [A] hospital located in an urban area, which has 100 or more beds, may receive such payments if it can demonstrate that more than 30 percent *of its inpatient care revenues (excluding any Medicare or Medicaid revenues)* are provided by State and local government payments for indigent care.

H. Conf. Rep. 100-495, 100th Cong., 1st Sess. 543, 1987 U.S.C.C.A.N., 2313-1289 (emphasis added). The emphasized passage clearly reflects the exclusion of Medicare and Medicaid revenues from the Pickle denominator.

Only if the statute is ambiguous are courts to inquire, under the second step of *Chevron,* whether the agency's interpretation is reasonable. *See id.* at 843-44. Here, the court of appeals erred in reaching step two of the *Chevron* analysis, as application of time-honored canons of statutory construction clearly proves that the Pickle Amendment is unambiguous.

Construction of the Pickle Amendment under the first step of *Chevron* "is guided by the fundamental canon that statutory interpretation begins with the language of the statute itself." *Pennsylvania Dep't of Public Welfare v. Davenport*, 495 U.S. 552, 557-58 (1990). And plainly, "the meaning of ['such'] is crucial to [that] analysis" here. *Id.* In contemplating the meaning of a word, "[c]ourts properly assume, absent sufficient indication to the contrary, that Congress intends the words in its enactments to carry their ordinary, contemporary, common meaning." *Pioneer Inv. Servs. Co. v. Brunswick Assocs. L.P.*, 507 U.S. 380, 388 (1993) (internal quotation omitted). That "such" plainly connotes something "[i]dentical with, being the same as what has been mentioned," should hardly be subject to dispute. BLACK'S LAW DICTIONARY, 1432 (6th ed. 1990). Stated differently, "'[s]uch' represents the object as already particularized in terms which are not mentioned, and is a descriptive and relative word, referring to the last antecedent." *Id.*

In the Pickle Amendment, "such" immediately precedes "net inpatient care revenues." Thus, consistent with its ordinary definition, "such" in this statutory provision refers to the last antecedent of "net inpatient care revenues." The last antecedent — indeed the only antecedent — is "net inpatient care revenues (excluding any of such revenues attributable to [Medicare] or [Medicaid])." 42 U.S.C. §

1395ww(d)(5)(F)(i)(II).[8] According to its dictionary definition, "'[s]uch' represents the object as already particularized;" thus, the parenthetical in this statute particularizes "net inpatient care revenues." BLACK'S LAW DICTIONARY, 1432 (6th ed. 1990).

1. The Secretary's Reading Conflicts With The Canon Of Construction Requiring That Every Word Of A Statute Be Given Effect.

The Secretary's strained attempt to circumvent the plain meaning of the word "such" is best illustrated by directly quoting her brief in the court of appeals: "The word 'such' . . . refers back to the totality of net inpatient care revenues and indicates that those revenues have already been mentioned in the statutory text." Brief for Appellant, at 28. On its face, this definition of "such" is so attenuated that it invites a rereading simply to grasp its meaning. The Secretary appears to take the position that the phrase "total *of such* net inpatient care revenues" is identical to the phrase "total net inpatient care revenues" and that the only role of the express term

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[8] The last (and only) antecedent of "net inpatient care revenues" does not incorporate the limitation "for indigent care from State and local government sources." 42 U.S.C. § 1395ww(d)(5)(F)(i)(II). If it did, the equation established by the Pickle Amendment would make no sense. That is, the numerator (net inpatient revenues excluding Medicare or Medicaid funds for indigent care from State and local government sources) would equal the denominator (the total of such net inpatient care revenues), a result which Congress could not have intended. Rather, the word "total," in the phrase "total of such net inpatient care revenues," makes clear that the phrase "for indigent care from State or local government sources" is excluded from the composition of the denominator. In other words, "total" indicates that the denominator includes all net inpatient care revenues (as modified by the parenthetical), not just those attributable to "indigent care from State and local government sources."

"such" in this statute is to remind the forgetful reader that a mere four or five lines earlier the phrase "net inpatient care revenues" had already appeared. This construction, however, means that "such" refers back to nothing because the passage identifying the Pickle denominator already plainly includes the words "net inpatient care revenues."[9]

The Secretary thus treats Congress' use of "of such" "essentially as surplusage — as words of no consequence." *Ratzlaf v. United States,* 510 U.S. 135, 140 (1994). As this Court has admonished, "[j]udges should hesitate so to treat statutory terms," *id.*, because it is a "cardinal principle of statutory construction that it is our duty to give effect, if possible, to every clause and word of a statute," *Bennett v. Spear,* 520 U.S. 154, 173 (1997) (internal quotations omitted). Indeed, well over a century ago this Court emphasized that:

> [w]e are not at liberty to construe any statute so as to deny effect to any part of its language. . . . As early

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[9] The parenthetical "(excluding any of such revenues attributable to [Medicare] or [Medicaid])" itself also contains the word "such," referring to "net inpatient care revenues." However, because such "is a descriptive and relative word, referring to the last antecedent," repeated uses of the word in the same statute do not necessarily have the same meaning. BLACK'S LAW DICTIONARY, 1432 (6th ed. 1990). Indeed, because the denominator already plainly includes "net inpatient care revenues," and because "such" in the parenthetical refers only to "net inpatient care revenues," interpreting both uses of the word "such" as having identical meanings would make "such" in the denominator mere surplusage. Rather, the first use of "such" modifies only the word "revenues," while the second use of the word "such" modifies "net inpatient care revenues." Thus, while the first use of "such" refers to the antecedent "net inpatient care revenues," the second use of "such" refers to the antecedent "net inpatient care revenues (excluding any of such revenues attributable to [Medicare] or [Medicaid])."

> as in Bacon's Abridgement, sect. 2, it was said that "a statute ought, upon the whole, to be so construed that, if it can be prevented, no clause, sentence, or word shall be superfluous, void, or insignificant."

Washington Market Co. v. Hoffman, 101 U.S. 112, 115-16 (1879). Simply put, the provision at issue here easily lends itself to a construction that gives meaning to every word. That analysis should end the matter.[10] Because the court of appeals' decision glaringly evades this fundamental principle, and because its proper application would compel the opposite result, further review is warranted.

This Court has recently utilized this principle to resolve questions of statutory construction under step one of *Chevron*. *See National Credit Union Admin. v. First Nat'l Bank & Trust Co.*, 118 S. Ct. 927, 939, 940 (1998) (finding an agency's interpretation of a statute "impermissible under the first step of *Chevron*" because it made a phrase "surplusage" when applied to certain facts). The subjective reasonableness of an agency's alternative interpretation, therefore, is irrelevant to a court properly engaged in giving effect to every word of a statute. In the instant case, however, the court of appeals buttressed its conclusion that the statute is ambiguous by citing the subjective reasonableness of the Secretary's parsing of the statutory language. *See* 172 F.3d at 96; App. at 12a

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[10] Indeed, the Secretary's construction assumes that when Congress said "total of such net inpatient care revenues," it really meant "total net inpatient care revenues." But if Congress meant "total net inpatient care revenues," it would have said so. *See K Mart Corp. v. Cartier, Inc.*, 485 U.S. 176, 188 (1988). By the same principle, if Congress had meant the Medicaid/Medicare exclusions to apply only to the Pickle numerator, it would have placed the parenthetical after the entire phrase "net inpatient care revenues for indigent care from State and local government sources," not after the antecedent "net inpatient care revenues," as it did.

(observing that "other features of the provision make the Secretary's interpretation of 'such' seem more than reasonable"). The court of appeals thus erroneously collapsed *Chevron* step one into the step two analysis, thereby turning on its head this Court's requirement that judges first apply principles of statutory construction to determine the plain meaning of particular legislation — irrespective of the reasonableness of the agency's view.

2. The Secretary's Reading Conflicts With This Court's "Deep Reluctance" To Construe A Statutory Provision So As To Render Another Provision Superfluous.

The Secretary's reading violates another well-established principle of statutory construction. This Court has repeatedly warned that "[o]ur cases express a deep reluctance to interpret a statutory provision so as to render superfluous other provisions in the same enactment." *Pennsylvania Dep't of Public Welfare v. Davenport*, 495 U.S. 552, 562 (1990) (citation omitted); *see also Hohn v. United States*, 118 S. Ct. 1969, 1976 (1998) (citing cases). The Secretary's construction, however, makes the Medicare exclusion in the Pickle Amendment meaningless.

In the Secretary's view, the parenthetical "(excluding any of such revenues attributable to [Medicare] or [Medicaid])" applies as a limitation only to the first occurrence of the phrase "net inpatient care revenues." 42 U.S.C. § 1395ww(d)(5)(F)(i)(II). In other words, if the Pickle Amendment were translated to a mathematical fraction, the exclusion for Medicare and Medicaid revenues would apply only to the numerator under the Secretary's reading. The denominator — which according to the statute is measured by the "total of such net inpatient care revenues" — would not reflect the exclusion of Medicare (or Medicaid) revenues.

Yet, in its description of the numerator, the Pickle Amendment also provides that only net inpatient care revenues "for *indigent care from State and local government* sources" are included. 42 U.S.C. § 1395ww(d)(5)(F)(i)(II) (emphasis added). With this qualification, Medicare funding — by its very nature — is excluded from the numerator, irrespective of whether the parenthetical is included in the provision. First, unlike Medicaid, Medicare does not provide revenues "for indigent care." While Medicaid is a welfare program, Medicare is a health insurance program. Indigence has no bearing on whether a patient qualifies for Medicare. *See* 42 U.S.C. §§ 426, 1395c, A.R. at 323-27.[11] Second, unlike Medicaid monies, Medicare revenues do not flow from "State and local government sources," but from the federal government. *See* 42 U.S.C. § 1395g. Thus, the parenthetical's exclusion of Medicare funds is utterly meaningless if not meant to apply to the denominator by virtue of the word "such." The Secretary's construction of the Pickle Amendment, adopted by the court of appeals, unnecessarily "render[s] superfluous other provisions in the same enactment." *Pennsylvania Dep't of Public Welfare,* 495 U.S. at 562. For this reason as well, further review is warranted.

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[11] To qualify for Medicare, an individual must (1) be aged 65 or over and qualify for social security benefits under title II of the Social Security Act; (2) be disabled and qualify for disability benefits under title II of the Social Security Act; or (3) have end stage renal disease. *See* 42 U.S.C. §§ 426, 1395c, A.R. at 323-26. An individual's income and resources are irrelevant to these eligibility criteria.

CONCLUSION

The petition for writ of certiorari should be granted.

Respectfully submitted,

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APPENDIX

APPENDIX A

United States Court of Appeals District of Columbia Circuit.

No. 98-5164

NORTH BROWARD HOSPITAL DISTRICT, *et al.*,
Appellees,

v.

Donna E. SHALALA, Secretary,
U.S. Department of Health and Human Services,
Appellant.

Appeal from the United States District Court
for the District of Columbia

Argued January 8, 1999
Decided April 27, 1999

Before SILBERMAN, SENTELLE, and RANDOLPH, Circuit Judges.

Opinion for the court filed by Circuit Judge SENTELLE.

SENTELLE, Circuit Judge:

Congress has authorized Medicare reimbursement at a higher than usual rate to certain large urban hospitals that receive significant state and local funding apart from Medicaid and Medicare revenues. The Secretary of Health and Human Services ("HHS") appeals a decision of the district court rejecting her interpretation of the qualifications for eligibility under this provision. *See North Broward Hosp. Dist. v. Shalala*, 997 F. Supp. 41 (D.D.C. 1998). Finding the statute

ambiguous and the Secretary's interpretation reasonable, we reverse.

I.

In 1983, Congress began to phase out the existing cost-based Medicare reimbursement system, *see* 42 U.S.C.§1395f(b)(1); *Methodist Hosp. of Sacramento v. Shalala*, 38 F.3d 1225, 1227 (D.C. Cir. 1994), and to phase in a "prospective payment" system providing reimbursement according to pre-determined rates based on diagnosis and geographic location. *See* Social Security Amendments of 1983, Pub. L. No. 98-21, § 601, 97 Stat. 65, 149 (1983) (codified as amended at 42 U.S.C.§1395ww). In 1986, recognizing that special adjustments might be needed for hospitals serving an unusually large number of low-income individuals, Congress crafted provisions implementing "disproportionate share" adjustments for such hospitals. *See* The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. No. 99-272, § 9105, 100 Stat. 82, 158 (1986). These disproportionate share adjustments provide for additional Medicare payments for hospitals that qualify on either of two grounds. Hospitals typically qualify for an adjustment by showing that they serve a disproportionate number of low-income patients based on the proportion of inpatient days attributable to Medicaid patients and to Medicare patients qualifying for Supplemental Security Income benefits.[1] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I), (v), (vi). Alternatively, under the provision at issue in this case, large urban hospitals can qualify by demonstrating that they receive state and local funding which exceeds a statutory

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[1] Supplemental Security Income furnishes financial assistance to indigent persons who are aged, blind, or disabled. *See* 42 U.S.C. § 1381 *et seq.*

threshold. Specifically, the statute provides for a disproportionate share adjustment for any hospital that

> is located in an urban area, has 100 or more beds, and can demonstrate that its net inpatient care revenues (excluding any of such revenues attributable to [Medicare or Medicaid]), during the cost reporting period in which the discharges occur, for indigent care from State and local government sources exceed 30 percent of its total of such net inpatient care revenues during the period.

Id. § 1395ww(d)(5)(F)(i)(II). As originally enacted in 1986, this provision read just as it does now, except that the phrase "total of such net inpatient care revenues" read "total of such revenues." *See* COBRA § 9105(a)(F)(i)(II), 100 Stat. 82, 158. The change to the present wording was made by a 1987 amendment. *See* The Omnibus Budget Reconciliation Act of 1987 (OBRA), Pub. L. No. 100-203, § 4009(j)(3)(A), 101 Stat. 1330, 1330-59 (1987).

The controversy in this case centers on the proper interpretation of the ratio specified in this provision. The single issue is whether the 30% set forth in the provision is a percentage of all net inpatient care revenues or whether it is a percentage of net inpatient revenues *excluding* revenues from Medicare and Medicaid. In other words, the question is whether the antecedent of "total of such net inpatient care revenues" is "net inpatient care revenues" or "net inpatient care revenues (excluding any of such revenues attributable to [Medicare or Medicaid])."

North Broward Hospital District ("North Broward"), doing business as Broward General Medical Center, North Broward Medical Center, and Imperial Point Medical Center, believed that the latter interpretation was correct, and that its

facilities therefore qualified for the disproportionate share adjustment for fiscal years 1989-1991. However, the Medicare fiscal intermediary adhered to the former interpretation, and accordingly refused to make the more generous reimbursements to North Broward. North Broward appealed to the Provider Reimbursement Review Board ("PRRB") as specified in 42 U.S.C. § 1395oo(a), (h). The PRRB adopted the latter interpretation of the ratio, reversed the intermediary's decision, and held that the North Broward facilities qualified for the disproportionate share adjustment. Next, at the urging of the intermediary and HHS's Bureau of Policy Development ("BPD"), the Administrator of the Health Care Financing Administration ("HCFA"), acting as the Secretary's delegate, reversed the Board's decision, as permitted by 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1875. The Administrator held that the provision contained "incontrovertible referential ambiguity" and that the former interpretation, adopted by the BPD and the intermediary, was reasonable. Pursuant to 42 U.S.C. § 1395oo(f)(1), the hospitals sought review in the district court, which in turn reversed the Administrator's decision and granted summary judgment for North Broward. The district court held that the language of the provision is clear and unambiguous and that it requires the latter interpretation, urged by North Broward. 997 F. Supp. at 45, 48. The Secretary appeals from this ruling of the district court.

II.

The practical differences between the Secretary's interpretation and that advanced by North Broward and accepted by the district court are significant. As an illustration of the implications of the two interpretations, consider an example of a hospital whose total net inpatient care revenues are $100,000,000, of which $40,000,000 are

Medicare and Medicaid revenues. Under North Broward's interpretation, which excludes Medicare and Medicaid revenues from the denominator of the ratio, the hospital would qualify for a disproportionate share adjustment under the provision at issue as long as it received more than $18,000,000 in state and local funding not attributable to Medicaid or Medicare, as illustrated by the following calculations:

North Broward's interpretation

Numerator = (State and local funding other than Medicare & Medicaid)
= $18,000,000

Denominator = (Net inpatient revenues, excluding Medicare & Medicaid)
= $100,000,000 - $40,000,000
= $60,000,000

The ratio is thus 18/60, or 30%.

Under the Secretary's interpretation, which does not exclude Medicare and Medicaid revenues from the denominator, the hospital would need to receive more than $30,000,000 of state and local funding not attributable to Medicaid or Medicare to qualify:

Secretary's interpretation

Numerator = (State and local funding other than Medicare & Medicaid)
= $30,000,000

Denominator = (Total net inpatient revenues)
= $100,000,000

The ratio is thus 30/100, or 30%.

Given the sizable difference in the amount of state and local funding required to qualify under the two interpretations, adopting North Broward's interpretation would likely increase the number of providers qualifying for the disproportionate share adjustment under the provision.[2]

Whether such an increase in the provision's applicability would be appropriate or desirable is a matter of policy, not of statutory construction, and within the bounds of congressional directive, it is primarily a question for HHS, not the courts. Because an agency's policy choices are necessarily constrained by the statute pursuant to which it acts, when an agency has interpreted a statute it administers, we first consider whether Congress has "directly addressed the precise question at issue." *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 843 (1984). If the intent of Congress is clear, it must be given effect. *Id.* However, if the intent of Congress is not clear, we do not impose our own construction of the statute, but instead examine only whether "the agency's answer is based on a permissible construction of the statute." *Id.* Thus, absent clear congressional intent to the contrary, we will defer to the Secretary's interpretation " 'if it is reasonable and consistent with the statute's purpose.' " *National Med. Enters., Inc. v. Shalala*, 43 F.3d 691, 695 (D.C. Cir. 1995) (quoting *Chemical Mfrs. Ass'n v. EPA*, 919 F.2d 158, 162-63 (D.C. Cir. 1990)). *See also HCA Health Servs. of Oklahoma, Inc. v. Shalala*, 27 F.3d 614, 616-17 (D.C. Cir. 1994); *Marymount Hosp., Inc. v. Shalala*, 19 F.3d 658, 661 (D.C. Cir. 1994).

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[2] According to HHS, fewer than a dozen facilities or hospital districts in the nation qualified under this provision in 1995. Secretary's Brief at 42; J.A. at 65.

North Broward advances two arguments that the usual *Chevron* analysis is inapplicable, neither of which we find convincing. First, North Broward argues that the Secretary's interpretation of the statute creating the ratio is not entitled to deference because it is not longstanding, noting that even the Administrator's decision characterized the regulations as silent with respect to the issue. We are somewhat puzzled by North Broward's argument, since the statutory interpretations of the agency's adjudicatory decision in this case would be entitled to deference even if the matter had never been addressed in regulations at all. *See Appalachian Regional Healthcare, Inc. v. Shalala*, 131 F.3d 1050, 1054 (D.C. Cir. 1997). There is certainly no argument that the Administrator's decision in this case is actually incompatible with the regulations. While perhaps not entirely unambiguous, the regulations describe the required ratio as 30 percent of "net inpatient care revenues" and are thus more consistent with the Secretary's interpretation of the statute than with the contrary position urged by North Broward. *See* 42 C.F.R. § 412.106(c)(2) (providing that the adjustment is available if a hospital "can demonstrate that, during its cost reporting period, more than 30 percent of its net inpatient care revenues are derived from State and local government payments for care furnished to indigent patients"). *See also* 51 Fed. Reg. 16,772, 16,776 (1986) (explaining that a qualifying hospital must show "that more than 30 percent of its total inpatient care revenues are from State and local government sources and that these revenues are specifically earmarked for the care of indigents").

Second, and even less convincingly, North Broward argues that the Secretary is not entitled to deference because of her "unremitting hostility" to disproportionate share adjustments in general. As evidence of this hostility, North Broward notes that Congress's 1986 enactment of statutory

disproportionate share adjustments arose in response to HHS's failure to implement acceptable adjustments by regulation, and that the House and Senate reports expressed dissatisfaction with the Secretary's nonresponsiveness. *See* H.R. Rep. No. 99-241, pt. 1, at 15-16 (1985); S. Rep. No. 99-146, at 291 (1985). As further evidence of the Secretary's alleged hostility to disproportionate share adjustments, North Broward points to cases rejecting the Secretary's interpretation of the statutory provisions governing disproportionate share adjustments based on a high proportion of low-income "patient days." *See, e.g., Cabell Huntington Hosp., Inc. v. Shalala*, 101 F.3d 984 (4th Cir. 1996); *Jewish Hosp., Inc. v. Secretary of HHS*, 19 F.3d 270 (6th Cir. 1994). Not surprisingly, North Broward cites no support for its suggestion that we should deny an agency *Chevron* deference because of our judicial assessment that it has been "hostile" to certain ideas. If an agency's "hostility" leads it to adopt an unreasonable interpretation of a statute, the interpretation will, if challenged, be rejected by the courts, as is perhaps illustrated by the cases cited by North Broward in which courts have rejected the Secretary's interpretation of the "patient-day" based disproportionate share mechanism. It is a far different thing to suggest that a court withhold deference to an agency's interpretation of a statute it administers on the basis of some sort of judicial "vote of no confidence" regarding the agency's actions on related matters. If Congress views HHS as "unremittingly hostile" to disproportionate share adjustments, it is free to decrease the agency's discretion in administering them or remove them from the agency's purview entirely. Absent such congressional intervention, administration of the provision at issue is entrusted to HHS, and our review is that prescribed by *Chevron*.

Finally, North Broward urges that even if *Chevron* applies, we need not conduct a *Chevron* analysis, because regardless of our view of the statute, the final decision by the HCFA Administrator was arbitrary and capricious and therefore violated the Administrative Procedure Act ("APA"). 5 U.S.C. § 706(2)(A); *see also* 42 U.S.C. § 1395oo(d) & (f)(1). In particular, North Broward relies on the fact that the Administrator's decision made reference to the fact that the phrase "such revenues" appears twice in the relevant sentence of the statute. North Broward accurately points out that while "such revenues" appeared twice in the statute before the 1987 amendment, it no longer does so--"such revenues" appears once, and "such net inpatient care revenues" appears once. Thus, appellees argue, the Administrator "did not even get the words of the statute right." North Broward Brief at 33. We find this argument hypertechnical. The Administrator's decision quoted the entire relevant statutory passage in two places, one immediately above the complained-of references to "such revenues." The statute was set forth correctly, with "such revenues" in one place and "such net inpatient care revenues" in the other. In light of this, it seems clear that the Administrator's reference to the two occurrences of "such revenues" was simply a shortening of the latter phrase by omitting the modifiers for ease of reference. Such shorthand may offend certain attorneys and copyeditors, but does not offend the APA. We therefore proceed to a *Chevron* analysis.

III.

Under the first step of *Chevron*, our task is to consider whether "the intent of Congress is clear" with respect to the interpretation of the state and local funding provision. *Chevron*, 467 U.S. at 842, 104 S. Ct. 2778. As we noted above, the statute provides for enhanced reimbursement if a hospital

> is located in an urban area, has 100 or more beds, and can demonstrate that its net inpatient care revenues (excluding any of such revenues attributable to [Medicare or Medicaid]), during the cost reporting period in which the discharges occur, for indigent care from State and local government sources exceed 30 percent of its total of such net inpatient care revenues during the period.

42 U.S.C .§ 1395ww(d)(5)(F)(i)(II). The Secretary argues that the statute is inherently ambiguous, in that "total of such net inpatient care revenues" might refer back to simply the entire category of "net inpatient care revenues" or might instead include the modifying parenthetical "(excluding any of such revenues attributable to [Medicare or Medicaid])." In contrast, North Broward argues that the statute is unambiguous, and that the Secretary's interpretation conflicts with the text of the statute. According to North Broward, by interpreting "total of such net inpatient care revenues" as identical with "net inpatient care revenues," the Secretary's interpretation fails to give effect to the words "of such."

North Broward's argument implicitly assumes that "such" is surplusage if it is not serving some limiting or particularizing role. The district court adopted a similar view. Relying on a portion of the definition of "such" from *Black's Law Dictionary*, which notes that "such" "represents the object as already particularized in terms which are not mentioned, and is a descriptive and relative word, referring to the last antecedent," *Black's Law Dictionary* 1432 (6th ed. 1990), the court concluded that "net inpatient care revenues (excluding any of such revenues attributable to [Medicare] or [Medicaid])" was the last antecedent, since the parenthetical phrase "particularizes" the object. *North Broward*, 997 F. Supp. at 45. In our view, this analysis takes too narrow a

view of the uses of the word "such." While it often serves the particularizing role envisioned by North Broward and the district court, the word "such" can also be used simply to refer back to something previously mentioned but not "particularized." As the Secretary notes, this use of "such" does not render the word surplusage--it still serves a role in "helping the reader to identify concepts that have already been employed in a long or complicated piece of writing." Secretary's Reply Brief at 18.

Where both a "particularizing" and a "non-particularizing" interpretation of "such" are possible, it need not be the case that the particularizing interpretation prevails. For example, in *Hogar Agua y Vida en el Desierto, Inc. v. Suarez-Medina*, 36 F.3d 177 (1st Cir. 1994), the court encountered a provision whose prefatory clause made the provision applicable to any "single-family house sold or rented by an owner," and whose following provisos referred to "such single-family houses." Although it was argued that the phrase in the provisos unambiguously related back to the complete phrase--"single-family house sold or rented by an owner," rather than to single-family houses generally, the court found the language ambiguous. *Id.* at 185-86. Accordingly, the court construed the statute in accordance with its remedial goals, and held that the references to "such single-family houses" did not incorporate the phrase "sold or rented by an owner," but rather simply referred to any single-family houses. *Id.* at 186.

United States v. Bowen, 100 U.S.(10 Otto) 508, 15 Ct. Cl. 619, 25 L. Ed. 631 (1879), upon which North Broward relies, is not to the contrary. In that case, the Supreme Court read the statutory phrase "all such pensioners" not to refer to all pensioners, but to a subset of pensioners previously described, noting that the alternate interpretation

would render "such" useless. *Id.* 100 U.S. (10 Otto) at 512. However, *Bowen* differs from the present situation in important respects. First, the provision considered in *Bowen* had not previously referred to the class of pensioners generally, but had *only* referred to a certain subset. Thus, the Court noted that "[t]here is no antecedent use of the word 'pensioners' in the [relevant] chapter ... to which the word *such* can refer, but the immediately preceding sentence in the same section." *Id.* Accordingly, "such" either had to refer back to the subset, or to nothing. That is not the case here. Second, the *Bowen* Court's task was not the same as ours. The *Bowen* Court had simply to choose between two interpretations of the statute. We must decide whether there is a clear congressional intent which precludes the Secretary's view. *Bowen* did not involve the rejection of the interpretation of those charged with administering the statute. Not only did *Bowen* long predate *Chevron*, but, as the pensioners there pointed out, the interpretation of the provision ultimately chosen by the Court had apparently been "uniformly given to it by the Commissioner of Pensions," who was charged with the duty of executing the statute. *Id.*, 100 U.S. (10 Otto) at 511.

Given a choice between attributing to "such" the simple referential function described by the Secretary or a particularizing function, we might ordinarily be inclined to choose the latter, which arguably gives "such" a more meaningful role. However, the provision at issue does not unambiguously require such an interpretation, and indeed, other features of the provision make the Secretary's interpretation of "such" seem more than reasonable. First, the denominator refers not simply to "such net inpatient care revenues" but to the "total of such net inpatient care revenues." North Broward correctly observes that if "such net inpatient care revenues" incorporated the exclusion of

Medicare and Medicaid revenues, then "total of such net inpatient care revenues" would as well. Nonetheless, we find the presence of the phrase "total of" at least suggestive that the phrase following is to be all-encompassing, without exclusions. Indeed, this seems the only way to give any real function to the phrase "total of."

In addition, the syntactical structure of the phrase describing the numerator makes it unusually difficult to isolate the antecedent of "such net inpatient care revenues" in the denominator. Even if we were intent on interpreting this phrase as referring to "net inpatient care revenues" as previously particularized, it would not be a simple task. This is so because the reference to "net inpatient care revenues" in the numerator is particularized not only by the parenthetical excluding Medicare and Medicaid revenues, but by two additional phrases as well. The numerator consists of "net inpatient care revenues (excluding any of such revenues attributable to [Medicare or Medicaid]), during the cost reporting period in which the discharges occur, for indigent care from State and local government sources." 42 U.S.C. §1395ww(d)(5)(F)(i)(II). North Broward makes sensible arguments explaining why the last two phrases cannot reasonably be read as being within the particularization incorporated by the "such" in the denominator, and we do not suggest that they are. But this reasoning necessarily departs from a simple rule that "such" always incorporates previous particularizations, and illustrates that the unwieldy formulation of the numerator makes blanket application of such a rule unworkable here. Given this, it is impossible to conclude that Congress clearly intended that "such" serve the specific particularizing role advanced by North Broward.

The Secretary argues that her interpretation is also bolstered by consideration of the provision's original wording

and the change made by the 1987 amendment. The sole modification to the provision made by the 1987 Act was to replace the requirement that the numerator "exceed 30 percent of [the hospital's] total of such revenues" with a requirement that the numerator "exceed 30 percent of [the hospital's] total of such net inpatient care revenues." *See* OBRA § 4009(j)(3)(A), 101 Stat. 1330, 1330-59. According to the Secretary, the 1987 change was merely intended to clarify that the phrase "total of such revenues" was not meant to indicate gross revenues rather than net. In the Secretary's view, this is supported by a string of words from the Conference Report accompanying the 1987 amendment (calling it a sentence would be too kind):

> [T]here has been controversy over the interpretation of current statutory language which refers to inpatient care revenues as "net inpatient care revenues" in one location, but refers to "such revenues" has been interpreted to mean either gross inpatient revenues (revenues the hospital would receive if all patients paid the hospital's full charges) or net inpatient revenues (gross revenues minus bad debts, contractual allowances, and charity care).

H.R. Conf. Rep. No. 100-495, at 543 (1987). While impossible to parse grammatically, this is the only passage in the legislative history to which we have been referred which meaningfully attempts to explain the motivation for the 1987 amendment. It provides at least minimal support for the Secretary's view of the purpose of that amendment.

Whether or not the 1987 amendment was made only to clarify the net versus gross issue, it was styled a "technical correction," *see* OBRA § 4009(j)(3)(A), 101 Stat. 1330, 1330-59, suggesting that only clarification and not substantive change was intended. Thus our concern is the meaning of the

phrase "such revenues" as used in describing the denominator of the ratio in the original 1986 enactment, and as "clarified" in 1987 to read "such net inpatient care revenues."

As originally enacted, the provision provided an adjustment for any hospital that could

> demonstrate that its *net inpatient care revenues* (excluding any of *such revenues* attributable to [Medicare or Medicaid]), during the cost reporting period in which the discharges occur, for indigent care from State and local government sources exceed 30 percent of its total of *such revenues* during the period.

COBRA § 9105(a)(F)(i)(II), 100 Stat. 82, 158 (emphasis added). The first occurrence of "such revenues" in this passage unambiguously referred back to "net inpatient care revenues." In the Secretary's view, the second occurrence of "such revenues" had the same meaning as the first, referring back simply to "net inpatient care revenues," and since the 1987 amendment did not implement any substantive change, the current "such net inpatient care revenues" language in the denominator has the same meaning. While we cannot assume that the antecedent of the second occurrence of "such revenues" would necessarily have to be the same as that of the first, we agree that the previous occurrence of "such revenues" with a clear antecedent does seem to provide at least some support for construing the latter occurrence of "such revenues" (and thus the amended "such net inpatient care revenues") as referring to the same antecedent.

The Secretary also asserts that her interpretation of the statute is the only one compatible with the legislative history of the original act, which indicated that the adjustment applied to a hospital if "at least 30% of its net inpatient care revenue

is provided by local or state governments for inpatient care for low-income patients not otherwise reimbursed by medicaid." H.R. Rep. No. 99-241, pt. 1, at 16. The House Report also states that "[t]he Committee further intends that *the denominator of this equation, net inpatient care revenue*, be defined according to the generally accepted accounting principles in the hospital industry; i.e., this factor should represent gross patient care revenues less deductions from revenue (other than contractual allowances), as those terms are generally used." *Id.* at 18-19 (emphasis added). We agree that these passages are consistent with the Secretary's view that the relevant state and local funding was required to be 30% or more of *total* net inpatient care revenues. The Conference Report further supports the Secretary's view, describing hospitals qualifying under this provision as "those which can demonstrate that more than 30 percent of their revenues are derived from State and local government payments for indigent care provided to patients not covered by medicare or medicaid." H.R. Conf. Rep. No. 99-453, at 461-62 (1985).

However, North Broward argues that since the present wording of the provision dates only from the 1987 amendment, the legislative history of that amendment, and not that of the original enactment, is the better source for determining Congress's intent. North Broward notes that in discussing "present law," the 1987 Conference Report noted that a hospital qualified under the provision at issue if "it can demonstrate that more than 30 percent of its inpatient care revenues (excluding any Medicare or Medicaid revenues) are provided by State and local government payments for indigent care." H.R. Conf. Rep. No. 100-495, at 543. The Conference Report further noted that the amendment "[c]larifies that a hospital would qualify if more than 30 percent of its net inpatient care revenues (excluding any

Medicare or medicaid revenues) are provided by State and local government payments for indigent care." *Id.* at 545. The Secretary argues, and we agree, that the 1987 Conference Report's characterization of existing law is entitled to little weight. As the Supreme Court has observed, subsequent legislative history is "an unreliable guide to legislative intent." *Chapman v. United States*, 500 U.S. 453, 464 n.4, 111 S. Ct. 1919, 114 L. Ed.2d 524 (1991). *See also Wright v. West*, 505 U.S. 277, 295 n.9, 112 S. Ct. 2482, 120 L. Ed.2d 225 (1992); *Pierce v. Underwood*, 487 U.S. 552, 566-67, 108 S. Ct. 2541, 101 L. Ed.2d 490 (1988). However, North Broward argues that because the 1987 legislative history accompanied an amendment to the provision at issue, its view of existing law deserves credit. While a discussion of existing law in subsequent legislative history may be more valuable where it accompanies a related amendment to the provision, *see Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 840, 108 S. Ct. 2182, 100 L. Ed.2d 836 (1988); *United States v. General Motors Corp.*, 518 F.2d 420, 436-37 (D.C. Cir. 1975), here there is no evidence that the exclusion of Medicare and Medicaid funds from the denominator of the ratio was the focus of attention of Congress, the Conference Committee, or even the author of the report. Hence the passages in the Conference Report on which North Broward relies as evidencing whether Medicare and Medicaid were intended to be excluded from the denominator are mere "legislative dicta," *Dunn v. Commodity Futures Trading Comm'n*, 519 U.S. 465, 478, 117 S. Ct. 913, 137 L. Ed.2d 93 (1997), and we do not view these remarks as speaking meaningfully to this issue.

Furthermore, even if we were inclined to give weight to the 1987 Conference Report, which we are not, it is not at all clear that the report, taken as a whole, supports North Broward's position. To be sure, in the passage cited by North

Broward, the Conference Report characterizes existing law as providing an adjustment if a hospital can demonstrate "that more than 30 percent of its inpatient care revenues (excluding any Medicare or Medicaid revenues) are provided by State and local government payments for indigent care." Because of the placement of the parenthetical after "revenues" rather than at the end of the sentence, this portion of the history is consistent with North Broward's interpretation. However, elsewhere in the same Conference Report, there is language encouraging the Secretary "expeditiously to implement the disproportionate share adjustment for hospitals which receive more than thirty percent of net patient revenues from State and local governmental sources," H.R. Conf. Rep. No. 100-495, at 525 (1987), and setting the amount of the adjustment at 15% for hospitals "which receive at least 30 percent of their net inpatient care revenues from State and local payments for indigent care," *id.* at 521. Because these portions of the report refer to the required ratio as 30% of net revenues with no reference to excluding Medicare and Medicaid, they do not support North Broward's interpretation. Thus, in our view, the only lesson to be drawn from the 1987 legislative history is that the individuals who wrote it had not carefully considered, or at least didn't quite agree on, what the original provision meant.

In sum, the provision's textual unwieldiness is not illuminated by this jumbled legislative history, and we cannot discern any clear congressional intent regarding the meaning of the provision. Accordingly, we agree with the Secretary that the provision is ambiguous, and proceed to the second step of the *Chevron* analysis.

IV.

We have little difficulty concluding that the Secretary's interpretation is a permissible construction of the provision. Indeed, the ambiguity of the provision described above arises largely because the provision is reasonably amenable to both the Secretary's and North Broward's readings. Nonetheless, North Broward argues that even if the Secretary's interpretation is a possible parsing of the provision's text, it is unreasonable in that it effectively penalizes hospitals for treating Medicare and Medicaid patients. This is so, the argument goes, because under the Secretary's interpretation, the more services a hospital furnishes to Medicare and Medicaid patients, the lower its ratio will be, since revenues for those services will be included in the denominator, but not the numerator. In contrast, North Broward suggests that under its interpretation, services to Medicare and Medicaid patients "do not help a hospital qualify for a disproportionate share adjustment ... but neither do they hurt the hospital." North Broward Brief at 39.

We find North Broward's argument unconvincing. First, even if increased Medicare and Medicaid funding adversely affected a hospital's ratio under *this* provision, hospitals treating an unusually large number of Medicaid and low-income Medicare patients are entitled to the disproportionate share adjustment under the alternate mechanism of 42 U.S.C. § 1395ww(d)(5)(F)(i)(I), (v), (vi). The provision at issue in this case seeks to identify and appropriately compensate hospitals receiving significant state and local funding for indigent care *apart from* Medicaid and Medicare spending. To the extent that an increase in Medicaid and Medicare revenues decreases the proportion of revenues attributable to other state and local funding, a

decrease in the hospital's ratio could well be what Congress had in mind.

More importantly, we are unconvinced of North Broward's factual premise--at least in some circumstances, it is the Secretary's interpretation, and not North Broward's, that is neutral with regard to services to Medicare and Medicaid patients. For example, suppose that in a given year, Hospital A and Hospital B each had total net inpatient care revenues of $100,000,000, of which $20,000,000 was state and local funding not attributable to Medicare or Medicaid. Suppose, however, that Hospital A received $40,000,000 net inpatient care revenues from Medicare and Medicaid, and $40,000,000 from other sources such as private insurance and individual payments, while Hospital B received $50,000,000 from Medicare and Medicaid and $30,000,000 from other sources. Thus, the only difference in the two hospitals' revenues is the amount of funding from Medicare and Medicaid versus private sources. The ratios calculated under this provision would be as follows:

Secretary's interpretation

Hospital A:	
Numerator	=$20,000,000 state and local funding
Denominator	=$100,000,000 total
Ratio	=20/100
Hospital B:	
Numerator	=$20,000,000 state and local funding
Denominator	=$100,000,000 total
Ratio	=20/100

North Broward's interpretation

Hospital A:
Numerator =$20,000,000 state and local funding
Denominator =$100,000,000 total - 40,000.00
Medicare & Medicaid
=$60,000,000
Ratio =20/60

Hospital B:
Numerator =20,000,000 state and local funding
Denominator =100,000,000 total - 50,000,000
Medicare & Medicaid
=50,000,000
Ratio =20/50

Under the Secretary's method, the fact that Hospital B had more services funded by Medicare and Medicaid than Hospital A leads to no difference in the ratios for the two hospitals. Under North Broward's method, however, Hospital B's greater Medicare and Medicaid funding leads to a higher ratio. We do not understand why North Broward views this as "neutral."

Furthermore, in some situations, this feature of North Broward's interpretation would lead to results which seem less consistent with the apparent purpose of the provision than would be the case under the Secretary's interpretation. For example, consider two otherwise qualifying hospitals, C and D, each of which has total net inpatient care revenues of $100,000,000, of which $10,000,000 is from Medicaid. Suppose that Hospital C receives heavy state and local funding not attributable to Medicaid or Medicare, in the amount of $23,000,000, while Hospital D receives $10,000,000 in such funds. One would expect that if either hospital would qualify

for a disproportionate share adjustment under the provision targeted at hospitals with unusually high state and local funding, it would be Hospital C. However, under North Broward's interpretation, as we understand it, this would not necessarily be the case. In particular, suppose that Hospital D is in an area with a large number of retirees, and therefore has a large amount of Medicare revenues totaling $60,000,000, while Hospital C has Medicare revenues of only $10,000,000. The calculations under North Broward's method would proceed as follows:

Hospital C:
Numerator = $23,000,000
Denominator = $100,000,000 - $10,000,000 Medicaid - $10,000,000 Medicare
= $80,000,000
The ratio is thus 23/80, which is less than 30%.

Hospital D:
Numerator = $10,000,000
Denominator = $100,000,000 - $10,000,000 Medicaid - $60,000,000 - Medicare
= $30,000,000
The ratio is thus
10/30 = 1/3, which is greater than 30%.

Thus despite its far greater state and local funding, Hospital C would not qualify for the adjustment under North Broward's interpretation, while Hospital D would. We note that the difference in Medicare funding that tips the balance in favor of Hospital D need not be for indigent elderly at all, but could equally as well be for wealthy seniors with Winnebagos and supplemental insurance. It is hard to see why serving a high number of such patients should affect Hospital D's ratio so favorably. We see little logic in this feature of North

Broward's interpretation, and cannot condemn the Secretary's failure to adopt it.

For the foregoing reasons, the decision of the district court is

REVERSED.

APPENDIX B

United States District Court,
District of Columbia.

NORTH BROWARD HOSPITAL DISTRICT
d/b/a Broward General Medical Center,
North Broward Hospital District
d/b/a/ North Broward Medical Center,
and North Broward Hospital District
d/b/a Imperial Point Medical Center,

Plaintiffs,

v.

Donna E. SHALALA, Secretary,
Department of Health and Human Services,

Defendant.

Civil Action No. 96-76 SSH.

March 9, 1998.

OPINION

STANLEY S. HARRIS, District Judge.

Before the Court are plaintiffs' motion for summary judgment, defendant's opposition thereto and cross-motion for summary judgment, plaintiffs' memorandum in opposition to defendant's dross-motion and in further support of their motion for summary judgment, and defendant's reply in support of its cross-motion for summary judgment. Upon consideration of the entire record, the Court grants plaintiffs'

motion and denies defendant's cross-motion. Although "[f]indings of fact and conclusions of law are unnecessary on decision of motions under Rule 12 or 56," Fed.R.Civ.P. 52(a), the Court nevertheless sets forth its reasoning.

BACKGROUND

Originally enacted in 1965, the Medicare program, title XVIII of the Social Security Act 42 U.S.C. §§ 1395 *et seq.*, provides health benefits to individuals who are over the age of 65, have a qualifying disability, or suffer from end-stage renal disease. *Id.* at § 1395c. Although defendant has primary responsibility for administering the Medicare program, some of that responsibility has been delegated to the Health Care Financing Administration ("HCFA"). The HCFA, in turn has entered into agreements with"fiscal intermediaries," under which the intermediaries act as agents of the Secretary by providing payment for services covered by Medicare.

Among other benefits, Medicare provides coverage for hospital services. In 1983, Medicare abandoned its system of reimbursing service providers for inpatient care according to the reasonable costs that the providers incurred, and adopted a Prospective Payment System ("PPS"). The PPS reimburses providers according to a predetermined set of payment rates for various diagnoses and procedures. 42 U.S.C. § 1395ww(d).

The PPS allows for numerous adjustments to its basic payment rates. Among them are adjustments for hospitals serving a significantly disproportionate share of low-income patients. *Id.* at § 1395ww(d)(5)(F). There are two methods for determining eligibility for a disproportionate share hospital ("DSH") adjustment: the "proxy method," *id.* at § 1395ww(d)(5)(F)(i)(I), and the "Pickle method," *id.* at § 1395ww(d)(5)(F)(i)(II).

Under the proxy method, a service provider qualifies for a DSH adjustment if a certain fraction of its total inpatient days are attributable to Medicaid patients and Medicare patients who receive supplemental security income.[1] *Id.* at §§ 1395 ww(d)(5)(F)(i)(I), 1395ww(d)(5)(F)(v) and (vi). Under the Pickle method, eligibility turns on a provider's share of net inpatient care revenues received from state and local government sources for indigent care.[2] *Id.* at 1395 ww(d)(5)(F)(i)(II). In particular, the Pickle method provides a DSH adjustment to a hospital that

> is located in an urban area, has 100 or more beds, and can demonstrate that its net inpatient care revenues (excluding any of such revenues attributable to this subchapter [Medicare] or State plans approved under subchapter XIX of this chapter [Medicaid], during the cost reporting period in which the discharges occur, for indigent care from State and local government sources exceed 30 percent of its total of such net inpatient care revenues during the period.

Id. A hospital eligible for a DSH adjustment under both the proxy and Pickle methods may receive an adjustment under

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[1] Medicaid is a cooperative federal-state program that provides health care to eligible low-income individuals. 42 U.S.C. § 1396 *et seq.*

[2] The "Pickle method" is named after the sponsor of this statutory provision, former Representative J.J. Pickle. It was created "[b]ecause of concern that this proxy measure of low-income status might substantially understate the presence of low-income patients in some hospitals, most particularly public hospitals in states where Medicaid eligibility standards are stringent." H.R.Rep. No. 99-241, at 18 (1986), *reprinted in* 1986 U.S.C.C.A.N. 579, 596.

the method producing the greater payment. 51 Fed.Reg 31458 (1986).

Plaintiffs are hospitals that provide inpatient services to Medicare recipients and low-income patients. Plaintiffs claimed entitlement to DSH adjustments under the Pickle method for fiscal years 1989-91. Compl. ¶¶ 15-16, at 5. After receiving input on these claims from HCFA, a fiscal intermediary denied all of plaintiffs' claims for adjustments.

Pursuant to 42 U.S.C. § 1395oo(a), plaintiffs appealed those decisions to the Provider Reimbursement Review Board ("PRRB"), an administrative body created to mediate Medicare disputes. Before the PRRB hearing, the parties agreed on all but one element of the methodology for determining eligibility for a DSH adjustment under the Pickle method: the intermediary maintained that the new inpatient care revenues used for the denominator include net inpatient care revenues attributable to Medicare and Medicaid; plaintiffs maintained that the net inpatient care revenues in the denominator exclude those net inpatient care revenues attributable to Medicare and Medicaid.[3] These divergent constructions turn on whether the "such" in the denominator incorporates the Medicare and Medicaid exclusions from the numerator's parenthetical phrase. On September 13, 1995, the PRRB unanimously reversed the decisions of the intermediary and granted plaintiffs' claims. *See* Administrative Record ("A.R.") at 57-72. Notably, the PRRB concluded that the plain meaning of the statute supported the exclusion of

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[3] The numerator is that part of the Pickle method, quoted above, that reads "net inpatient care revenues (excluding any of such revenues attributable to [Medicare and Medicaid]), during the cost reporting period in which the discharges occur, for indigent care from States and local government sources." The denominator reads "total of such net inpatient care revenues during the period."

Medicare and Medicaid revenues from the denominator. *Id.* at 69.

On November 16, 1995, the HCFA Administrator reversed the PRRB's decision. *Id.* at 2-12. The Administrator concluded that the statute contained "incontrovertible referential ambiguity" and that the legislative history did not directly address the issues of the case. *Id.* at 11. The Administrator concluded that, in light of the asserted textual ambiguity, HCFA's original construction of the statute, which included Medicare and Medicaid revenues in the denominator, was "reasonable" and "neither arbitrary nor capricious from a policy standpoint." *Id.* at 12.

Plaintiffs filed this action under 42 U.S.C. § 1395oo(f)(1), seeking declaratory and monetary relief. In their motion for summary judgment, which seeks reversal of the Administrator's decision, plaintiffs claim that (1) the Pickle method requires the exclusions of Medicare and Medicaid revenues from the denominator, and (2) the Administrator's decision was contrary to the Medicare statute, arbitrary and capricious, and otherwise contrary to law under the Administrative Procedure Act ("APA"), 5 U.S.C. § 551 *et seq.* In their cross-motion for summary judgment, defendants contend that (1) Congress has clearly indicated that the denominator of the Pickle method includes Medicare and Medicaid revenues, and (2) even if Congress has not clearly indicated the inclusion of Medicare and Medicaid revenues, defendant's interpretation of the denominator should be upheld as reasonable. Upon consideration of the entire record, the Court grants plaintiffs' motion.

STANDARD OF REVIEW

Summary judgment may be granted only when there is no genuine issue as to any material fact and the moving party is entitled to judgment as a matter of law. Fed.R.Civ.P. 56(c);

Celotex Corp. v. Catrett, 477 U.S. 317, 322, 106 S.Ct. 2548, 91 L.Ed.2d 265 (1986). Because the issues raised by these motions concern only questions of statutory interpretation, they are appropriate for resolution on a motion for summary judgment.

For guidance in resolving the pending motions, the Court looks to the framework for reviewing an agency's construction of a statute set forth in *Chevron U.S.A., Inc. v. National Resources Defense Council, Inc.*, 467 U.S. 837, 842-43, 104 S.Ct. 2778, 81 L.Ed.2d 694 (1984). Under *Chevron*, a court must first ascertain "whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expresses intent of Congress." If, however, a court concludes that the statute is ambiguous or silent on the relevant question, it will defer to the agency's construction of the statute as long as it is "permissible."[4] *Id.* 467 U.S. at 843.

A court must employ "traditional tools of statutory construction" to determine whether Congress has addressed a particular issue. *Chevron*, 467 U.S. at 843 n.9. Accordingly, "the beginning point must be the language of the statute, and when a statute speaks with clarity to an issue[,] judicial inquiry into the statute's meaning, in all but the most

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[4] Defendant argues that under *Chevron*, 467 U.S. at 865, her interpretation of the Medicare statute is due "special deference" because "the regulatory scheme is technical and complex." However, the passage that she quotes from *Chevron* forms part of the Supreme Court's analysis under the second prong, which applies only upon a finding that Congressional intent is unclear. *Id.* at 842. Where, as here, the Court finds that the intent of Congress is clear, defendant's interpretation is not entitled to deference. *Id.* at 843 n. 9; *Fertilizer Inst. v. EPA*, 935 F.2d 1303, 1309 (D.C. Cir. 1991).

extraordinary circumstances, is finished." *Estate of Cowart v. Nicklos Drilling Co.*, 505 U.S. 469, 475, 112 S.Ct. 2589, 120 L.Ed.2d 379, (1992); *accord Negonsott v. Samuels*, 507 U.S. 99, 104, 113 S.Ct.1119, 122 L.Ed.2d 457 (1993). Thus, plain language controls statutory construction, absent a "clearly expressed legislative intention to the contrary." *Qi-Zhuo v. Meissner*, 70 F.3d 136, 140 (D.C.Cir. 1995) (quoting *Reves v. Ernst & Young*, 507 U.S. 170, 177, 113 S.Ct. 1163, 122 L.Ed.2d 525 (1993)).

ANALYSIS

Plaintiffs prevail under the first prong of *Chevron* because a plaint language analysis supports their construction of the Pickle denominator.[5] First, the words in the statute describing the denominator, when given their ordinary meaning, support plaintiffs' interpretation. Second, this interpretation succeeds in giving effect to every word describing the denominator. Last, there is no "clearly expressed legislative intent" which undermines this reading of the Pickle denominator.

As noted, the crux of the parties' disagreement turns on whether the reference to "such net inpatient care revenues" in the denominator incorporates the Medicare/Medicaid exclusion expressed in the numerator. Because "[c]ourts properly assume, absent sufficient indication to the contrary, that Congress intends words in its enactments to carry their ordinary, contemporary, common meaning," *Pioneer Inv. Servs. Co. v. Brunswick Assocs. L.P.*, 507 U.S. 380, 388, 113 S.Ct. 1489, 123 L.Ed.2d 74 (1993) (internal quotations omitted), the Court looks to the plain meaning of "such." This word denotes:

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[5] Because the Court rules for plaintiffs pursuant to the first prong of *Chevron*, it need not address plaintiffs' APA challenge.

> Of that kind, having particular quality or character specified. Identical with, being the same as what has been mentioned. Alike, similar, of the like kind. "Such" represents the object as already particularized in terms which are not mentioned, and is a descriptive and relative word, referring to the last antecedent.

Black's Law Dictionary 1432 (6th ed. 1990). As applied to the Pickle method, because the "such" in the denominator immediately precedes "net inpatient care revenues," it must refer to the last antecedent of "net inpatient care revenues." This last antecedent is "net patient care revenues (excluding any such revenues attributable to [Medicare] or [Medicaid])." 42 U.S.C. § 1395ww(d)(5)(F)(i)(II). The denominator must incorporate the parenthetical phrase excluding Medicare or Medicaid revenues because that phrase modifies "net inpatient care revenues."[6] In effect, the parenthetical phrase "particularize[s]" the "object." *Black's Law Dictionary* 1432 (6th ed. 1990).

Furthermore, a construction of the Pickle denominator that incorporates the exclusion of Medicare and Medicaid revenues gives effect to all of the words in the denominator. *See Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 145 (D.C.Cir. 1986) (where possible, courts must construe statutes to give effect to every word Congress used). Under this construction, "such" refers to net inpatient care revenues as modified by the Medicare/Medicaid exclusion. Additionally, "total," which immediately preceded "such,"

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[6] The antecedent does not include "for indigent care from State and local government sources" because that clause serves to distinguish the numerator from the denominator. *See infra* n. 9 and accompanying text.

refers to the whole of this amount.[7] In other words, "total" clarifies that the denominator includes all of the modified net inpatient care revenues, and not simply that portion attributable to "indigent care from State and local government sources."[8] Hence, it distinguishes the numerator from the denominator.[9]

By contrast, defendant's construction of the statute fails to effectuate every word in the Pickle denominator. Defendant contends that "such net inpatient care revenues" in the denominator must refer to all net inpatient care revenues because the previous use of "such" in the parenthetical phrase referred to all net in patient care revenues, including those

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[7] "Total" means "[w]hole, not divided, lacking no part, entire, full, complete, the whole amount. Utter, absolute." *Black's Law Dictionary* 1490 (6th ed. 1990).

[8] The Court disagrees with defendant's contention that this construction of the Pickle denominator renders the term "total" meaningless.

[9] Accordingly, the Court disagrees with defendant's argument that an application of the "last antecedent" definition to "such" must also include the limitation "for indigent care from State or local government sources" in the denominator since this clause also modifies the original "net patient care revenues." The insertion of the term "total" clarifies that the phrase "for indigent care from State or local government sources" distinguishes the composition of the numerator from that of the denominator. Moreover, as defendant concedes, Def.'s Mem. in Opp. to Pls.' Mot. and in Supp. of Cross-Mot. at 38, such a construction would lead to the absurd result of the numerator always being equal to the denominator, a result the Court readily presumes Congress did not intend. *See Hughey v. JMS Dev. Corp.* 78 F.3d 1523, 1529 (11th Cir.), *cert. denied*, 519 U.S. 993, 117 S.Ct. 482, 136 L.Ed.2d 377 (1996); *In re Pacific-Atlantic Trading Co.*, 64 F.3d 1292, 1303 (9th Cir. 1995).

attributable to Medicare and Medicaid.[10] Because "identical words used in different parts of the act are intended to have the same meaning," *Gustafson v. Alloyd Co.*, 513 U.S. 561, 115 S.Ct. 1061, 131 L.Ed.2d 1, "especially when . . . repeated within a given sentence," *Brown v. Gardner*, 513 U.S. 115, 118, 115 S.Ct. 552, 130 L.Ed.2d 462 (1994), defendant contends that the "such" in the denominator must parallel that in the parenthetical phrase. This argument, however, strains credulity because "such" is a "descriptive and relative" term, the meaning of which depends on the last antecedent. *Black's Law Dictionary* 1432. Thus, by definition, "such" cannot automatically acquire the same meaning as that of a prior use of the word. However, even assuming that this rule of statutory construction applies in this instance, defendant's interpretation still fails to effectuate the term "of such." Without that term, the denominator reads "total net inpatient care revenues." If added, the term "of such" becomes surplusage because the denominator already expresses the meaning defendant ascribes to "of such," namely, that the denominator includes all net inpatient care revenues. Because courts should seek to avoid treating statutory terms as surplusage, *Bailey v. United States*, 516 U.S. 137, 116 S.Ct. 501, 506-507, 133 L.Ed.2d 472 (1995), defendant's construction cannot attach to the Pickle denominator.

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[10] In making this argument, defendant focuses on a sentence in the definition of "such" which reads, "[i]dentical with, being the same as what has been mentioned." *Black's Law Dictionary* 1432. Defendant distorts the meaning of this sentence. "Identical with" refers to the previous use of the object that the term "such" modifies; it does not refer to the previous use of "such" *per se*. Thus, "such net inpatient care revenues" is "identical with" the net inpatient care revenues that "ha[ve] been mentioned" – those modified by the Medicare/Medicaid exclusion.

The plain language of the statute controls the interpretation of the statute, absent a "clearly expressed legislative intention contrary to that language, which would require [the Court] to question the strong presumption that Congress expresses its intent through the language it chooses." *INS v. Cardoza-Fonseca*, 480 U.S. 421, 432 n. 12, 107 S.Ct. 1207, 94 L.Ed.2d 434 (1987) (internal quotation omitted); *accord Qi-Zhuo*, 70 F.3d at 140. The Court finds no such intention because the legislative history is unclear, and thus inconclusive.

Congress originally enacted the Pickle amendment as part of the Comprehensive Omnibus Budget Reconciliation Act of 1986 ("COBRA")., Pub.L. No. 99-272, 100 Stat. 158 (1986). Shortly thereafter, Congress amended the Pickle denominator in the Omnibus Budget Reconciliation Act ("OBRA") of 1987, Pub.L. No. 100-203, 101 Stat. 1330-59 (1987), by inserting the words "net inpatient care" to clarify whether the revenues in the denominator referred to net or gross revenues.[11] The OBRA's legislative history includes two references to the formula for the Pickle denominator. The first reference is in a section of a House Conference report that describes the Pickle method before the 1987 amendment:

> Additional payments are made to PPS hospitals that serve a disproportionate share of low-income patients. Under one criterion, a hospital located in an urban area, which has 100 or more beds, may receive such payments if it can demonstrate that more than 30 percent of its inpatient care revenues (excluding any Medicare or Medicaid revenues) are

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[11] In the COBRA legislation, the denominator had read "total of such revenues."

> provided by State and local government payments for indigent care.

H.R. Conf. Rep. No. 100-495, at 543 (1987), *reprinted in* 1987 U.S.C.C.A.N. 2313-1245, 2313-1289. The second reference describes the change made by the 1987 amendment, which

> [c]larifies that a hospital would qualify if more than 30 percent of its net inpatient care revenues (excluding any Medicare or Medicaid revenues) are provided by State and local government payments for indigent care.

Id. at 545, *reprinted in* 1987 U.S.C.C.A.N. at 2313-1291. Both passages support plaintiffs' construction of the Pickle denominator because the Medicare/Medicaid exclusion immediately follows the denominator. If the exclusion applied only to the numerator, the parenthetical modifier would have followed the term "[those revenues] provided by State and local government payments for indigent care." Thus, the OBRA legislative history validates the Court's plain language interpretation of the Pickle denominator.

Nevertheless, the earlier COBRA legislative history undermines this interpretation. In relevant part, the history consists of reports for Conference and House committees and reads:

> The Secretary would be required to make disproportionate share payments where a hospital can demonstrate that more than 30 percent of its net inpatient care revenues is provided by local or state governments for inpatient care for low income patients not otherwise reimbursed by Medicare or Medicaid.

H.R. Conf. Rep. No. 99-453, at 459 (1986).

> This exception process would require the Secretary to make disproportionate share payments . . . where the hospital can demonstrate that 30% or more of its net inpatient care revenue is provided directly or indirectly by local or State governments for inpatient care not otherwise reimbursed by Medicaid.

H.R.Rep. No. 99-241, at 18 (1986), *reprinted in* 1986 U.S.C.C.A.N. 579, 596. These passages contradict those in the OBRA legislative history insofar as the Medicare/Medicaid exclusion follows, and hence only modifies, the numerator.[12]

Because the passages from the OBRA and COBRA legislative histories conflict with one another, they form an inappropriate aid to the interpretation of the Pickle denominator. *See Qi-Zhuo*, 70 F.3d at 140 (inconsistent legislative history cannot override plain statutory language). Indeed, the "legislative history is more conflicting than the text is ambiguous." *Wong Yang Sung v. McGrath*, 339 U.S. 33, 49, 70 S.Ct. 445, 94 L.Ed. 616 (1950). Having determined that the plain language of the statute supports

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[12] The House report also states:

> The Committee further intends that the denominator of this equation, net inpatient care revenue, be defined according to the generally accepted accounting principles in the hospital industry[.]

H.R.Rep. No. 99-241, at 18 (1986), *reprinted in* 1986 U.S.C.C.A.N. at 596. The Court concludes that this passage is ambiguous; although it suggests that the denominator is "net inpatient care revenue," the purpose of the sentence is to clarify the calculation of net inpatient care revenues. Thus, for ease of expression, the committee simply may have omitted a specific reference to the Medicare and Medicaid exclusion. As defendant herself notes, a committee's report is not drafted "meticulously." *See International Bhd. of Elec. Workers v. NLRB*, 814 F.2d 697, 712 (D.C.Cir. 1987); *Abourezk v. Reagan*, 785 F.2d 1043, 1054-1055 n.11 (D.C.Cir. 1986), *aff'd*, 484 U.S. 1, 108 S.Ct. 252, 98 L.Ed.2d 1(1987).

excluding Medicare and Medicaid revenues from the Pickle denominator, the Court should not and will not resort to legislative history to obscure an otherwise unambiguous statutory text. *See Ratzlaf v. United States*, 510 U.S. 135, 147-148, 114 S.Ct. 655, 126 L.Ed.2d 615 (1994).

In reaching this conclusion, the Court rejects defendant's arguments that it should not consider the OBRA legislative history because that history does not represent the reflection of the Congress that originally enacted the Pickle amendment, and because the statutory changes enacted by Congress in the OBRA did not bear on the exclusion of Medicare/Medicaid revenues from the denominator. Although "the opinion of [a] later Congress as to the meaning of a law enacted . . . earlier does not control the issue" of statutory interpretation, *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 839-840, 108 S.Ct. 2182, 100 L.Ed.2d 836 (1988), the Court will "by no means eschew the guidance" offered by "the understanding of a subsequent Congress as to the actions of an earlier one." *Heckler v. Turner*, 470 U.S. 184, 209, 105 S.Ct. 1138, 84 L.Ed.2d 138 (1985). Moreover, this later Congress did not idly comment on the formula for the Pickle denominator, but rather expressed its interpretation while enacting statutory changes.[13] Therefore, the Court properly may consider the OBRA legislative history. Having done so, it concludes that the legislative history of the Pickle amendment, as a whole (and as so often is true), provides an

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[13] Even though these changes did not necessarily pertain to the Medicare/Medicaid exclusion, they still indicate that Congress devoted a greater degree of attention to the issue than if it had not made any changes to the statute.

obscure and unreliable source of guidance on Congressional intent.[14]

CONCLUSION

In sum, the plain meaning of the Pickle denominator indicates that Congress has directly and clearly addressed the issue of excluding Medicare and Medicaid revenues therefrom. Because the Pickle amendment's legislative history is conflicting and unclear, it does not belie this conclusion by rendering the statute "ambiguous" under *Chevron*'s first prong. Thus, the Court concludes that the Pickle denominator excludes those net inpatient care revenues attributable to Medicare and Medicaid. Accordingly, the Court grants plaintiffs' motion for summary judgment and denies defendant's cross-motion for summary judgment.[15] An appropriate Judgment accompanies this Opinion.

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[14] Even if the Court considered only the COBRA's legislative history, however, it would still conclude that the legislative history is inconclusive. Defendant principally relies on three passages from committee reports. As already noted, one of these passages is ambiguous. *See supra* n. 12. Moreover, defendant's argument against according too much weight to the OBRA's legislative history, because committee reports are not drafted "meticulously," applies with equal force to the COBRA's history. Finally, and tellingly, in reversing the decision of the PRRB in favor of defendant, the HCFA Administrator found that the COBRA's history did not provide "direct support" for defendant's statutory interpretation. A.R. at 11.

[15] In their complaint, plaintiffs suggest that they may seek reimbursement for attorneys' fees and other costs associated with this action. If plaintiffs still seek any such relief, the parties should file a joint briefing schedule with the Court within 14 days of the date of this Opinion.

JUDGMENT

For the reasons stated in the accompanying Opinion, it hereby is

ORDERED, that plaintiffs' motion for summary judgment is granted. It hereby further is

ORDERED, that defendant's motion for summary judgment is denied. It hereby further is

ORDERED, that the net inpatient care revenues used in the denominator of the formula to determine a Medicare adjustment under the Pickle amendment, 42 U.S.C. § 1395ww(d)(5)(F)(i)(II), are declared to exclude net inpatient care revenues attributable to Medicare and Medicaid. It hereby further is

ORDERED, that the HCFA Administrator's decision of November 16, 1995, is reversed. It hereby further is

ORDERED, that defendant shall pay plaintiffs the amounts in controversy, plus interest in accordance with 42 U.S.C. § 1395oo(f)(2). It hereby further is

ORDERED, that if plaintiffs still seek reimbursement for attorneys' fees and other costs, the parties shall file a joint briefing schedule within 14 days of the date of this Order.

SO ORDERED.

APPENDIX C

United States Court of Appeals
for the District of Columbia Circuit

No. 98-5164
September Term, 1998
(96cv00076)

NORTH BROWARD HOSPITAL DISTRICT
d/b/a/ North Broward Medical Center,
and North Broward Hospital District
d/b/a Imperial Point Medical Center,

Appellees

v.

Donna E. SHALALA, Secretary,
Department of Health and Human Services,
Appellant

Filed July 6, 1999, Clerk

BEFORE: Silberman, Sentelle and Randolph,
Circuit Judges

ORDER

Upon consideration of appellees' petition for rehearing filed June 11, 1999, it is

ORDERED that the petition be denied.

Per Curiam

FOR THE COURT
Mark J. Langer, Clerk
By: /s/ Robert A. Bonner
Deputy Clerk

APPENDIX D

United States Court of Appeals
for the District of Columbia Circuit

No. 98-5164
September Term, 1998
(96cv00076)

NORTH BROWARD HOSPITAL DISTRICT
d/b/a/ North Broward Medical Center,
and North Broward Hospital District
d/b/a Imperial Point Medical Center,

Appellees

v.

Donna E. SHALALA, Secretary,
Department of Health and Human Services,
Appellant

Filed July 6, 1999, Clerk

BEFORE: Edwards, Chief Judge; Wald, Silberman, Williams, Ginsburg, Sentelle, Henderson, Randolph, Rogers, Tatel and Garland, Circuit Judges

ORDER

Upon consideration of appellees' petition for rehearing en banc, and the absence of a request by any member of the court for a vote, it is

ORDERED that the petition be denied.

Per Curiam

FOR THE COURT
Mark J. Langer, Clerk

By: /s/ Robert A. Bonner
Deputy Clerk

APPENDIX E

42 U.S.C. § 1395ww(d)(5) provides in relevant part:

(F)(i) For discharges occurring on or after May 1, 1986 . . ., the Secretary shall provide, in accordance with this subparagraph, for an additional payment amount for each subsection (d) hospital which –

> **(I)** serves a significantly disproportionate number of low-income patients (as defined in clause (v)), or
>
> **(II)** is located in an urban area, has 100 or more beds, and can demonstrate that its net inpatient care revenues (excluding any of such revenues attributable to this subchapter [Medicare] or State plans approved under subchapter XIX of this chapter [Medicaid]), during the cost reporting period in which the discharges occur, for indigent care from State and local government sources exceed 30 percent of its total of such net inpatient care revenues during the period.